

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Tangonan Adult Residential Care Home	CHAPTER 100.1
Address: 94-228 Moena Place Waipahu, Hawaii 96797	Inspection Date: May 16, 2019 Annual

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> Resident #1 – No annual Tuberculosis skin test available for review</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><b><u>FINDINGS</u></b> SCG #1, SCG #2, SCG #3, SCG #4, &amp; SCG #5 - PCG training not available for review</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> Resident #1 -</p> <ul style="list-style-type: none"> <li>• “Amlodipine Besylate 5mg by mouth 1 tab every day hold if S B/P &lt;105” ordered 1/22/18, however, not transcribed to MAR for the months of 9/2018 to 5/16/19. Discontinue order unavailable for review.</li> <li>• Ensure dietary supplement in use. No Physician/APRN order available for review.</li> <li>• Pressure ulcers noted by RN Case manager on 5/10, 6/18, 9/18/2018 and 1/19, 2/19, 3/19/2019. No Physician/APRN order/instructions available for review.</li> <li>• “Dulcolax rectal suppository 10mg 1 suppository as needed PR daily PRN constipation 2 days”, however, MAR not initialed as given despite activity record indicating no BM for 2 days for the month of 5/2018.</li> </ul>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-84 <u>Admission requirements.</u> (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information:</p> <p>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.</p> <p><b><u>FINDINGS</u></b> Resident #1 - Current documentation of FLU vaccine not available for review</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u> (e)  The primary care giver with the assistance of the case manager shall provide training to all substitute care givers and ensure that all services and interventions indicated in the expanded ARCH resident's care plan are provided to expanded ARCH residents by the substitute care giver.</p> <p><b><u>FINDINGS</u></b>  Resident #1– No documentation of Case Manager training for SCG #3 &amp; SCG #4 available for review</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_